PILOT PROJECT FOR CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES IN COLORADO

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
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Consumer Directed Attendant Support Waiver Proposal

A. Executive **Summary**

1. General Purpose

In 1996, the Colorado General Assembly passed a law which was designed "to analyze the feasibility and cost-effectiveness of a consumer-directed attendant support program that promotes self-sufficiency, self-reliance, and a sense of personal responsibility in persons with disabilities who make appropriate attendant support decisions." Accordingly, the Colorado Department of Health Care Policy and Financing (HCPF) is requesting waivers of federal regulations to conduct a Consumer Directed Attendant Support demonstration program to provide existing recipients of Medicaid funded home care services with funds to enable them to manage their own attendant support. The demonstration program is intended to increase the independence and self-sufficiency of participants, to improve the quality of attendant support that participants receive, and to decrease the cost to the state for providing participants with attendant services.

The demonstration program is designed to give participants greater flexibility and control in the management of their attendant support. The design assumes a high level of consumer direction in the program, and the composition and role of the program advisory committee reflect that assumption. The program is intended to place participants in the role of making decisions about attendant support, while avoiding placing undue burden on them for personnel and financial administration.. The demonstration is also designed to provide incentives for savings and flexible spending to program participants.

The department, the advisory committee and the legislature acknowledge that this demonstration may expose participants to greater risk, both in terms of quality of care and financial exploitation. While it is true that shifting agency control to the consumer involves increased risk, the program has been designed to minimize unnecessary risk and to assure the quality of services. Quality assurance measures will be used throughout the program to ensure better access to care, better quality of care, positive participant outcomes, strong consumer satisfaction and prudent and efficient use of funds. Quality assurance measures will include existing elements from the state program and other approaches specifically designed for the demonstration.

2. Program Design Features

The state will enroll up to 150 individuals in the demonstration program. Participants must already meet Medicaid eligibility and must have received Medicaid funded attendant support for twelve months. All participation will be voluntary. The funds that are normally paid to home health agencies for services will instead be provided to participants, based on individual utilization. Program

participants will receive mandatory training on attendant support develop an Attendant Support Management Plan, approved by the program administrator, which will describe the participant's current status and will establish individual goals and outcomes. When individuals leave the demonstration program, additional participants will be enrolled to fill vacant slots.

Case managers will be available to assist all participants in planning and administering their attendant support. Case managers will assist the state in quality assurance and service monitoring functions. The department will utilize case managers, who are part of the state's Long Term Care "Single Entry Point" (SEP) agencies, who provide services to participants under Home and community Based Services waivers.

The department will contract with "Fiscal Intermediary" organizations to provide financial and personnel administration for participants. The Fiscal Intermediaries will be the employers of record for the attendants and will handle taxes, withholding, benefits, payments and other personnel and accounting activities. The participants will be the supervising employers, and will hire, train and supervise their attendants, and will negotiate with attendants for wages. Thus the participants will have control of their attendant support services without taking on the added responsibility of personnel administration.

Each program participant will receive a monthly allocation of funds based on the individual's history of utilization of Medicaid funded attendant support. The department will send the monthly allocations to the appropriate Fiscal Intermediary to make all necessary disbursements, under the direction of the participant. The Fiscal Intermediary will make payments to attendants only upon receipt of timesheets, signed by both the program participant and the attendant, which show the hours of attendant services provided.

Any unspent portion of a participant's allocation will be divided between the state, as cost savings, and the individual participant. As part of the attendant support management plan, the participant will identify the designated purpose for use of the savings. The participant may use this savings incentive to cover costs for other services and equipment that promote the participant's independence. This might include assistive devices, home renovations related to independent living such as installation of safety rails and access ramps, or skills training which would Support independent living in the community.

Any savings accrued by the participant will also be administered and disbursed by the Fiscal Intermediary under the participant's direction. In no circumstance will cash payments be made to program participants.

B. Environment

1. Background

A group of individuals with disabilities and disability advocates began meeting in 1995 to explore alternatives for providing personal assistance serv!ces to consumers in Colorado. All participants favored increasing consumer direction and control in whatever design was selected. The group began with a model provided by the United Cerebral Palsy Association, but several members believed strongly that legislation was needed to suppcrt any meaningful new approach.

During legislative hearings on health care reform, members of the disability community in Colorado presented the concept of consumer directed personal assistance services using Medicaid funding. Several members of the legislature were interested in this approach and encouraged the formation of a working group to develop legislation. This group included staff from the Colorado Department of Human Services, the Department of Health Care Policy and Financing, and several members of the disability community. The efforts of the working group led to the passage of Colorado Law 96-178, the legislation that established the Consumer Directed Attendant Support pilot program (see attached).
Once the legislation passed, HCPF began the implementation of CDAS. The legislation mandated strong community input and participation in the program. All parties believed that consumer direction in program development was necessary considering the nature of CDAS. A program advisory committee was formed which consisted largely of members of the original working group. The committee, which is composed primarily of people with disabilities, is dedicated to the success of CDAS and to including all stakeholders in program development. Thus, during the summer of 1998, the committee decided to expand its membership to enhance community representation. (A current list of committee members is attached.) HCPF is committed to maintaining the advisory committee as a strong and active partner throughout the development, implementation and operation of CDAS.

2. Overview of Current System

Medicaid recipients in Colorado can currently receive attendant support through any of several programs. These include:

a. Home and Community-Based Services for the Elderly, Blind & Disabled (HCBS-EBD) - The HCBS-EBD Program offers services, as an alternative to nursing facility care, to clients eighteen years of age and older who are blind, physically disabled or elderly; who pass the level of care screen for nursing facility care; are financially eligible for Medicaid long term care; and can be safely sewed in the community at no more than the cost of nursing home care. The last full year data showed 8,608 HCBS-EBD clients, and of those, 4,956 received regular personal care services, and 1,291 received personal care services from a relative.

b. Home and Community-Based Services for Persons Living With AIDS (HCBS-PLWA) - The HCBS-PLWA Program provides home and community-based services to Medicaid eligible persons with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) as an alternative to institutional placement in a hospital or nursing facility. The maximum number of recipients under this waiver is 172.

c. Home Health (HH) - Home Health Care is an entitlement program for Medicaid eligible clients of any age when services are prescribed by a physician and are medically necessary. Skilled services include nursing, physical therapy, occupational therapy, speech therapy, and home health aide services. Colorado has been experiencing a dramatic increase in Home Health services, with an average of 2,472 individuals being served each mcnth during state fiscal year 1998.

d. Home Care Allowance (HCA) - The Home Care Allowance Program provides for a monthly cash payment for the purchase of in-home services to approximately 5,800 low-income, frail elderly or disabled clients in Colorado. This payment enables clients who are in need of long term care services for activities of daily living to remain in their own homes. This state-funded program provides paicipants with a maximum payment of $396 a month.

3. **Experience with Waivers**

Colorado has two approved Section 1115 demonstration waivers. Both are managed by the Delivery Systems Development Section of the Office of Program Development, the section that will also manage the proposed waiver program. The Integrated Care and Financing Program was approved on July 1, 1997 and is in the process of implementation, after lengthY negotiations with HCFA over Medicate rate setting methodologies. The other 1115 waiver authorized implementation of a Home Health Aide pilot project called "Alternatives in Medicaid Home Care Delivery." This program is similar to the one being proposed. It allows Colorado Medicaid to pay Home Health agencies differently for a particular target population, and allows services to be provided outside the home. This waiver was approved in the spring of 1998.

4. Public View of Current System

While people with disabilities in Colorado feel fortunate that the state provides some attendant support through the Home Health program and through certain waivers, many experience significant frustration at the restrictions imposed by traditional home health agencies. One individual, Laura Hershey, expressed the sentiments of many in the disability community in a recent copyrighted internet article:

Here in Colorado, for example, we're lucky enough to have Medicaid-funded attendant services. [...] People with significant disabilities can get up to eight or ten hours a day of personal assistance. This enables thousands of Coloradans to live and participate in their communities, to go to school, to work or volunteer, to raise their families, and to spend their time as they see fit.

And while this is certainly a more liberated lifestyle than confinement in a nursing home would be, Colorado's Medicaid-funded attendant services come with their own restrictions. These services must be provided by a state-certified home health agency, which in turn must hire state-certified "nursing assistants" (CNA's). [...] When CNA's go into the home of a disabled client, they are technically working under the supervision of a registered nurse in an office across town.

Some people regard Medicaid's training and supervision requirements as reasonable quality-control measures. But for the majority of people with physical disabilities, they impose unnecessary and onerous limitations on our ability to manage and supervise *(Copyright 1998 by Laura Hershey. Reprinted with permission from "Crip Commentary," Laura Hershey's weekly web column, available on line at: http.//ourworld, compuserve, com/homepages/LauraHershey).*

The Executive Director of a statewide advocacy organization, who serves on the program's advisory committ.ee and on the Medicaid Advisory Committee for People with Disabilities, put forth her views of the existing program:

Our current public health care system in terms of providing home health care, while one of the best in the nation, can still be improved upon. Our system is totally reliant upon agencies with a small exception for family caregivers that are expected to do twice the work for less than half the pay. This system works for some people and does not work for many more. Agencies control who provides the services and when they are provided along with a host of rules such as mandatory nursing visits which do not benefit the consumer and drive costs. In rural communities many people get either inadequate or no services because the few agencies there cannot find the people to staff the needs of people with severe disabilities. The individual with a disability with their own funds could hire neighbors, family members and others who may not want to endure the training and other requirements of an agency. Even in the urban areas it is difficult to find an agency which will cater to the needs of the working person with a disability, i.e. sending aides at 6:00 a.m. Finally, the dynamic of providing personal care is so intense and private that if the aide feels they are working for anyone other than the client the potential for abuse and exploitation is great. While some may want the perceived security of agencies, consumer control is the preferred mode for those people with disabilities who are empowered and want 100% control over their lives.

Another consumer summed up her perspective, "I have CP. I'm not sick. Why do I need a nurse to tell (the attendants) or me what to do. I can do that myself. Why does the system assume that people with disabilities need medical help?"

Another consumer from the advisory committee has a different perspectqe:
So much of what constitutes health-care and welfare reform is unfortunately articulated as attacks on government, as attacks on clients of the state or as attacks on professional delivery of services. Welfare reform can reform without reducing services to the indigent persons who require them. Hopefully, our attempt at reform will sensibly retain client access to expert medical care and to the resources of governmental oversight of the private industries that deliver health care.

Though most of the home health and medical community believe the current system is working well, many acknowledge that many people with disabilities can and should manage their own attendant services. Both the home hea, lth agency representative and the Colorado Board of Nursing representative on the program s advisory committee have expressed concern that consumers' safety and health be protected as a part of CDAS, but they strongly support the idea of designing a system to give consumers more control and flexibility in managing their attendants.

5. Public Input
The CDAS program is a direct outcome of the passage of state legislation. That legislative process included two House committee hearings and two Senate committee hearings as well as public readings of the proposed law. Representatives of various stakeholder groups provided input to the legislature during the process. The bill passed with strong bipartisan support in the legislature and with little opposition from any community group.
Once the legislation passed, HCPF began the implementation of CDAS. The legislation mandated strong community input and participation in the program. All parties believed that consumer direction in program development was necessary considering the nature of CDAS. - A program advisory committee was formed which consisted largely of members of the original working group. The committee, which is composed primarily of people with disabilities, is dedicated to the success of CDAS and to including all stakeholders in program development. Thus, during the summer of 1998, the committee decided to expand its membership to enhance community representation. (A current list of committee members is attached.) HCPF has a strong belief and proven track record of working with Medicaid customers and providers as partners. The department is committed to maintaining the advisory committee as a strong and active partner throughout the development, implementation and operation of CDAS.

As the CDAS program moves through the process of obtaining a federal waiver and promulgating rules, community members will have further opportunity for

input. Drafts of the waiver proposal have been reviewed by the CDAS Advisory Committee and by the Medicaid Advisory Council for Persons with Disabilities. Proposed program regulations will also be reviewed by each of these committees and by at least two other advisory committees.
HCPF and the program advisory committee will produce public awareness materials to be distributed throughout Colorado. One of these documents (attached) is a fact sheet outlining the basic design and intent of CDAS. This fact sheet is being distributed to human service agencies, disability organizations, and any other entities that express interest in learning about CDAS. Another slightly more detailed brochure will be developed for use in informing potential participants of the benefits, responsibilities, and opportunities for those enrolling in CDAS. Announcements of the CDAS program will appear in various disability-related newsletters prior to the beginning of enrollment.

C. Program Administration

1. Organization Structure

The Consumer Directed Attendant Support program will be organized and administered by the Colorado Department of Health Care Policy and Financing. The Department of Health Care Policy and Financing was created in 1994 to be a focus for reform and innovation in health care delivery and financing in Colorado. The mission of the department is to improve access to health care services. The Department is the Single State Medicaid agency.

The program will be directed by Dann Milne, P.h.D.., Manager of the Delivery Systems Development Section. The l:)Url:)ose of the section is to develop systems of health care delivery so as to reduce cost and/or improve access and quality. Dr. Milne is a member of the National Academy for State Health Policy, Long Term Care Committee, and serves on the Academy's Advisory Committee on Managed Care for the Elderly and Persons with Disabilities. He is a member of the National Association of State Medicaid Directors Long Term Care Technical Advisory Group (TAG) to HCFA. He has managed the design, development and implementation of a single entry point access system for long term care, the Colorado Primary Care Physician (Section 1915b waiver) Program, and several Home and Community Based Services (Section 1915c waiver) programs. He also directs the Colorado Integrated Care and Financing Project.

The Delivery Systems Development section is part of the Office of Program Development (OPD), directed by Barbara Ladon. The mission of OPD is to analyze, develop and implement health care system innovations that improve consumer access, quality and effectiveness of health care services in collaboration with public and private sector partners.

Administration of the Consumer Directed Attendant Support program will involve a full-time administrator and a half-time administrative assistant. The duties of the administrator are to write waivers and rules, develop forms, and set up fiscal systems during the development phase of the program. Once implemented, the administrator will have the ongoing responsibilities for tracking payments and utilization, training case managers in the pilot program's requirements, overseeing the Peer Review Organization in utilization reviews, establishing review teams, and working with clients.
Bill West will serve as the Administrator for CDAS. Mr. West has worked in the disability arena for eighteen years, including work in independent living, consumer advocacy, vocational rehabilitation and assistive technology. Mr. West is a person with a disability and is active in the disability community in Colorado.

2. Contractual Relationships

The demonstration program will contract with one or more entities to serve as a Fiscal Intermediary for processing payments for participants. Depending upon participants' needs, some contractors may provide other services, such as providing lists of individuals who are interested in serving as attendants. The contractors' administrative fees will be set during the contract process.

The criteria for selection of the Fiscal Intermediary(s) include:

a) Commitment to and interest in the tenets of consumer direction. b) Ability or experience in working with individuals with disabilities. c) Ability to establish relationships/rapport with other community organizations. d) Ability to manage consumer payments. e) Ability to provide appropriate and timely Fiscal Intermediary services. f) Commitment to work cooperatively with project staff for the purpose of quality control and evaluation.

Contractors will be selected in accordance with the State of Colorado Procurement Code and Rules, 24-101-101 through 24-112-101-10, specifically Article 103, Source Selection and Contract Formation. The demonstration program will follow the contract Management Guide, 1997 to establish documentation and reporting requirements so as to ensure that the contractors are fulfilling all obligations under the contract. Payments to contractors will be in accordance with all State fiscal rules. The Program Administrator will supervise the performance of all contractors.

3. Systems Support

The demonstration program will utilize existing systems currently available to the administering department and to other state and local offices. The administrative staff will manage all fiscal matters through the Colorado Financial Recording System (COFRS) accounting. Both SEP case managers and

administrative staff will use the existing Client Oriented Information System (COIN) to handle enrollment information. Contractors will be required to have fiscal systems in place, in accordance with Statements of Auditing Standards as set forth by the American Institute of Certified Public Accountants.

D. Eligibility

1. Medicaid Eligibility

By statute, all CDAS participants must be eligible for Medicaid. Thus, the demonstration program will conform with all Medicaid eligibility conditions and requirements as described in the current Colorado State Plan for Medical Assistance.

2. Program Eligibility Criteria

The CDAS legislation describes program eligibility in terms of eight factors. An eligible individual must:

a) Be willing to participate in the pilot program;
b) Be eligible for Medicaid;
c) Demonstrate a current need for attendant support and have received Medicaid-funded attendant support for the past twelve months;
d) Document a predictable need for attendant support and a pattern of stable health, such as a person with a disability who seeks appropriate treatment for illnesses and conditions;
e) Provide a statement from his or her primary care physician that indicates the individual has sound judgment and is in stable condition;
f) Demonstrate the ability to handle the financial aspects of self-directed attendant care;
g) Demonstrate the ability to manage the health aspects of his or her life; and
h) Demonstrate the ability to supervise attendants and to give clear directions.

The legislation also states "This pilot program may include persons whose gross income does not exceed three hundred percent of the current federal supplement security income benefit level and who are eligible for a home and community-based program. Participantswho meet eligibility on this basis will substitute the CDAS benefit for personal care services under a Home and Community Based Services waiver, though they will continue to receive other HCBS services. Participation in the demonstration by these individuals will not effect their Medicaid eligibility.

Though the above program eligibility is set forth by the governing legislation, several of the critical terms lack definition and may be interpreted in a variety of ways. Specifically, the terms "pattern of stable health," "stable condition,"

"ability to handle the financial aspects of self-directed attendant care," "ability to manage the health aspects of his or her life," and "ability to supervise attendants" need to be defined for the demonstration so as to ensure equal opportunity for all appropriate applicants and to avoid any unlawful discrimination. The department and the advisory committee will devote significant time and energy to defining these terms during the process of promulgating rules for the program.

3. Eligibility Categories

Individuals who meet the above eligibility requirements and who want to direct their attendant services can be enrolled in CDAS. Participation will be strictly voluntary. By statute, the demonstration program will include not more than 150 individuals at any time. Participants could come from any of the Colorado Medicaid eligibility groups but are most likely to be persons eligible to receive payments under Supplemental Security Income, Aid to the Needy Disabled, Aid to the Needy Blind, Old Age Pensioners A or B. Because of the program eligibility requirement that participants "... have received Medicaid-funded attendant support for the past twelve months", participants will have been enrolled and receiving services under Medicaid Home Health or under a Home and Community Based Services waiver that provides Personal Care services.

4. Administration of Eligibility

Individuals interested in participating in CDAS may apply in any of a variety of ways. Long Term Care "Single Entry Point" (SEP) agencies will provide individuals with applications and can assist them in the completion of application forms. Many disability organizations in the state, such as independent living centers, can provide interested individuals with forms and application assistance. Individuals may also contact the Colorado Department of Health Care Policy and Financing for information and to acquire an application.

Interested individuals will submit applications and supporting documentation to the Administrator of the Consumer Directed Attendant Support program at the Colorado Department of Health Care Policy and Financing. The Administrator, in conjunction with the Eligibility Review Committee, will review all applications and determine which applicants meet program eligibility. All applicants will receive written notification as to whether they have been determined eligible for the demonstration, along with a legal notice of participants' rights to fair hearing, grievance and appeal procedures, as described in Colorado State Rules vol. 8, "Medical Assistance", sections 8.057 through 8.059. The first 150 eligible applicants will be referred for mandatory attendant support management training. Individuals who meet all eligibility requirements, complete the training and pass the attendant management proficiency test will be enrolled in the program. If more than 150 applicants are determined eligible for the demonstration, the department will establish a waiting list on a first-come, first-served basis.

The demonstration has been designed so that the somewhat lengthy eligibility and enrollment procedures will not create hardships for participants. Applicants for the demonstration will continue with their existing attendant support arrangements while they complete the training and other enrollment procedures. One of the final steps in the training will involve setting up in the demonstration program, participants will be disenrolled from any other Medicaid funded attendant support.

E. Benefits

The demonstration program is specifically intended to add consumer directed attendant support as a benefit of the Colorado Medicaid program for this target population. Receipt of this benefit will not impact any other benefits currently available to participants, except that participants will substitute this benefit for home health aide services or personal care service under a Home and Community Based Services waiver.

The demonstration has been designed to assure continuity of care for program participants. Applicants for the demonstration will continue with their existing attendant support arrangements while they complete the training and other enrollment procedures. One of the final steps in the training will involve setting up new consumer-directed attendant support, so as to avoid any break in service. Once receiving services in the demonstration program, participants will be disenrolled from any other Medicaid funded attendant support.

F. Delivery Network

Within the demonstration program, all services will be delivered on a fee-for-service basis. Consumers will contract for the attendant support they need, either with attendants through a fiscal Intermediary, or by contracting with a provider agency for emergency back-up support. In either case, the individual consumer will determine with whom they contract and at what rate. Thus, participation by any provider will be based on whether consumers in the program choose to contract with them. Rates will be determined based on negotiations between the consumer and the attendant support provider, and such rates will be considered reasonable in that the consumer and provider agree to them. The state will not impose restrictions on rates that participan.ts can pay providers, except to require that rates must adhere to minimum wage guidelines.
Case managers through the Single Entry Point agencies will be available to assist consumers in identifying potential providers and to provide guidance on fee negotiations if desired. The case managers will not negotiate on behalf of consumers, nor will they have more than an advisory role in establishing service plans or rates. Case managers will assist the department in quality assurance activities. They will be available to assist consumers who wish to disenroll from the demonstration and to re-enroll in other attendant support services. Case

managers will have received training on the demonstration from the program administrator.

The program has been designed to provide participants with a smooth transition from traditional attendant services to the demonstration, and to avoid duplicate payments to providers. Applicants for the demonstration will continue with their existing attendant support arrangements while they complete the training and other enrollment procedures. One of the final steps in the training will involve setting up new consumer-directed attendant support, so as to avoid any break in service. Once receiving services, participants will be disenrolled from any other Medicaid funded attendant support.

1. Capacity

Given the program eligibility requirement that participants "... have received Medicaid-funded attendant support for the past twelve months," it is evident that the capacity to meet participants needs has been sufficient immediately prior to the beginning of the program. Any or all of the existing providers could be utilized in the demonstration, depending upon consumer preference. In addition, participants in the demonstration will be hiring their own attendant support and many will likely be new providers, thus increasing capacity. Individuals-living in some rural regions oi: the state have reported that the availability of support from providers in their areas is quite limited. The consumer directed model will expand the capacity of attendant support, particularly in rural areas, as consumers can hire individuals not associated with a provider agency.

2. Emergencies

Participants in the demonstration will be responsible for making arrangements to cover emergencies based on individual preference. Since participants will have been receiving attendant support for twelve months as required by program eligibility, They will have had some experience managing emergencies. As part of the mandatory attendant support management training, participants will develop a plan that will include handling emergencies. This might include arrangements for back-up coverage through attendant support provider agencies, through arrangements with individuals willing to provide emergency support, or through some combination of approaches. Participants who repeatedly fail to manage emergencies effectively will be considered for disenrollment.

3. Marketing and Outreach

The State will do all marketing of the demonstration program with cooperation from disability-related community agencies. The marketing and enrollment materials will be written in languages, and at an educational level appropriate to potential participants. Disability organizations in the state, such as consumer associations and independent living centers, will be available to assist potential

participants in learning about and understanding the demonstration program. Potential participants will also learn about the program through existing attendant support providers and other consumers, which, along with disability organizations, will likely be the major sources for referrals for attendants. Other marketing by provider agencies and individuals will not be restricted, as participants will need as much information as possible to assist them with finding attendant support.

4. Enrollment

Consumers can be enrolled in the demonstration program only after completing the attendant support management training and passing the attendant support management proficiency test. The program administrator will then contact the individual in writing to notify him or her that enrollment can proceed pending the determination of a services start date. The administrator will give each individual the calculated amount of attendant support funds available and a 30-day window of time in which to finalize attendant support arrangements administrator and the consumer agree on the service date, the administrator will nctify the fiscal intermediary and the SEP case worker of the consumer's enrollment and projected service start date, and of the funding available for that individual. The consumer and the fiscal intermediary, with support from the case manager, will need to complete a contract for services. Program staff will confirm the services start date with the consumer within 72 hours of that date. The administrator will notify the state fiscal agent to cease payments for all existing Medicaid funded attendant support for the consumer as of that person's service start date. The administrator will notify the individual and his or her current Medicaid provider of the date tha.t existing payments will cease.

Consumers can disenroll from the demonstration at any time. A consumer who wishes to disenroll will need to contact the SEP case manager or the program administrator to be disenrolled from the demonstration and to re-enroll in their previous Medicaid funded attendant support program. None of the existing Medicaid funded programs which provide attendant support have a ceiling on the number of individuals who can be served, so that re-. enrollment should not be a problem. When individuals leave the demonstration, additional participants will be enrolled to fill the vacant slots.

Consumers who fail to comply with demonstration program requirements or who demonstrate an inability to manage their attendant support may be disenrolled by the Eligibility Review Committee. Consumers whose physical or mental conditions have deteriorated to where they may no longer meet the admission criteria may also be considered for disenrollment. The Eligibility Review Committee will review cases, brought to the attention of the program administrator by case managers or through the administrator's direct monitoring and periodic review, to determine if the consumer continues to be appropriate for the Project and whether any action can be taken to establish continuing

eligibility. If so, the committee will make recommendations to the individual for changes in his or her attendant support program. If not, the consumer will be informed through a legal notice that he or she is no longer eligible for the demonstration program, and that other home care services are ..being authorized based on the needs of the consumer. The legal notice will provide information to the consumer about participants' rights to fair hearing, grievance and appeal procedures, in accordance with Colorado State Rules vol. 8, "Medical Assistance", sections 8.057 through 8.059. The authorization for home care services will follow the same process used in the traditional program. This notification will be provided to the fiscal intermediary and SEP caseworker as appropriate.

Enrollment or disenrollment in the demonstration program will have no effect on general Medicaid eligibility or enrollment.

H. Quality Assurance

In this demonstration, consumers are responsible for the management of their health and of their attendant services. This responsibility includes quality assurance and financial reconciliation. The monitoring and reconciliation activities are designed to support consumer management, rather than to be a separate structure as in traditional home care agencies.

Prudent management of Medicaid funds. Quality assurance activities by other entities are designed to support and augment those of consumers (see attached chart).

1. Consumer Role

By volunteering to participate in the demonstration, consumers will be assuming the responsibility for managing their own health and for assessing the quality of care received under the demonstration, in contrast to the traditional model of service delivery. By having direct control of the support provided, consumers can control the quality of that support. Consumers will have first-hand knowledge of the quality of care, as they are present when the care is provided, unlike typical supervising nurses, who primarily assess the quality of care after the fact. Attendants will be responsible directly to consumers and will therefore be more responsive to consumers standards for health and quality. Consumer health and satisfaction with services will be measured as part of the program evaluation.

All eligible applicants for the demonstration program will be referred for mandatory attendant support management training. Applicants will receive training on a variety of topics including hiring and supervising attendants, recognizing and getting quality attendant support, managing their own health, *communication* skills, financial management and participants' rights and

responsibilities. The training will highlight participants' rights to fair hearing, grievance and appeal procedures, and participants' responsibilities to report abuse, neglect or *exploitation.* Training on Hiring attendants will include recruiting, interviewing, negotiating rates and performing reference checks. Participants will receive training on effective use of case manager and Fiscal Intermediary services. Trainers will encourage participants to contact case managers, the program administrator or other community supports when they need help in solving problems.

Several individuals from the program advisory committee, who are consumers of attendant services, have begun to develop a preliminary curriculum for the attendant support management training. This group, which includes representatives from independent living centers and consumer advocacy organizations, will work with department staff and some attendanl:service providers to continue the curriculum design. The design team will base the curriculum on similar products from consumer-directed programs in other states, along with perspectives from individuals who have significant experience in directing their own attendant support. The department will contract with independent living centers and other consumer agencies to provide the training. The trainers and the design team will modify the curriculum throughout the life of the program, based on experience and feedback from participants.

As consumers are concluding the attendant support management training, they will each develop an attendant support management plan, which will describe their current status and will establish individual goals and outcomes for the next 12 months. Completion of an appropriate plan will be a requirement for passing the training course. Though the case manager and the program administrator will have copies of all plans, the plans are intended primarily as guides for participants. Goals and outcomes can be personal (e.g., improve ability to perform a function) or relate to the care provided (e.g., assure a reliable service provider each day). The plan will also include the consumer's plans for handling emergencies and goals for financial savings.

During the pilot, all plans must be approved by the program administrator. Participants whose plans are disapproved may request a review of that disapproval. The administrator will convene a panel of three consumers of attendant support to provide such a review. The administrator and the program advisory committee will develop specific criteria and guide!ines for this approval and review during the process of developing overall program rules.

At least once a year, consumers, with support from case managers, will review their attendant support management plans, evaluate changes in their status, determine their success in obtaining their goals and desired outcomes and establish goals and outcomes for the next year. The consumer evaluation process can occur at any time if consumers need to -change their service plans.

Program participants will submit weekly timesheets to the appropriate Fiscal Intermediary showing hours worked by each attendant. The timesheets will have space provided for the participant to comment on the quality of services provided by the particular attendant. The participant may choose to share any of these comments with the case manager or the program administrator. In the process of reviewing the submitted timesheets, the Fiscal Intermediary will note any evaluative comments regarding attendants and pass these along to the program administrator as an additional quality check.

In addition to the service plans, each participant will be asked to complete a self assessment every three months. The self assessment will give the consumer the opportunity to identify strengths, areas of growth and areas of concern, particularly in terms of overall health, attendant support management, quality of care and general satisfaction with the program. The self assessment, which will be sent to the case manager or program administrator as appropriate, will also serve as a prompt to the consumer to contact the case manager or program administrator about questions or problems.

2. Fiscal Intermediary Role

Since the Fiscal Intermediary is legally acting on behalf of the consumer, there must be a solid understanding between the Fiscai Intermediary and the consumer as to their respective roles and how they relate. In order to receive a state contract, Fiscal Intermediaries must establish and maintain quality assurance programs which monitor and evaluate the quality of services provided to consumers. Fiscal Intermediaries will perform the following activities related to quality assurance:

a) Ensure that consumers are informed of the procedures and forms to use in reporting any change in workers and for reporting the hours worked by all attendants.
b) Perform background checks on potential attendants.
c) Review weekly attendant worker payment invoices for consumer comments or complaints.
d) Monitor the consumer's submittal of the required information to determine that it is complete, accurate and timely.
e) Report consumers' performance of employment related activities to case managers and program staff as requested.
f) Work with case managers and program staff to address consumer performance
g) Maintain individual accounts for each consumer.
h) Establish and maintain quality assurance programs which monitor and evaluate services.
i) Provide reports to consumers for the purpose of monitoring and financial

reconciliation, as specified in contracts with the state and with the consumer.
j) Provide reports to the state as specified.

The Fiscal Intermediary will be required to provide a monthly report to each consumer documenting:

• funds received,
• payments made to each attendant,
• taxes, unemployment insurance, workers' compensation, benefits and other funds
withheld for attendants,
• funds spent on other purchases,
• the Fiscal Intermediary's service charge,
• total funds disbursed,
• monthly cost savings, and
• the account balance *available* for future use.

The Fiscal Intermediary will provide the state with copies of all client reports. In addition, the Fiscal Intermediary will provide the state with monthly aggregate data for all clients. Program staff will cross check the reports with the state invoice to ensure proper distribution of funds.

3. Case Manager Role

Case Managers will play an important role in the demonstration in terms of consumer support and quality assurance. The department will utilize case managers, who are part of the state's Long Term Care "Single Entry Point" (SEP) agencies, who provide services to participants under Home and community Based Services waivers. A significant number of the likely participants in the demonstration are already receiving HCBS services and will be known to the SEP agencies. These case managers will have received training and orientation to the demonstration from the program administrator prior to working with program participants.
Case managers will be available to assist program participants in a variety of ways, depending upon the needs of the individual. The responsibilities of case managers for quality assurance and reconciliation of cash balances include the following:

a) Address consumers' needs for case management and support on an individual basis, recognizing that people develop skills differently.
b) Assist consumers in establishing and maintaining relationships with Fiscal Intermediaries as needed.
c) Contact consumers at least quarterly to discuss their service plans, attendant management issues, budgets and general satisfaction.
d) Contact the Fiscal Intermediary periodically to determine status of the consumers' activities, if applicable.

e) Assist consumers in securing related services, such as reassessments, as needed.
f) Notify the program administrator when problems arise.
g) Assist consumers who become disenrolled in returning to previous attendant support services.

Case managers will Contact participants twice a month during the first three months of consumer participation to assess their attendant management, their satisfaction with care providers and the quality of services received. Participants will then be contacted by case managers every three months during the life of the demonstration to provide on-going monitoring. During these contacts, case managers will assess consumers' attendant management, quality of care and consumer satisfaction. They wilt review participants'
expenditures, and implementation of their overall plan. The program staff and advisory committee will develop a set of questions to be used by the case managers in assessing consumer satisfaction and quality of services purchased through the demonstration.

4. Departmental Role

The Department of Health Care Policy and Financing will assure quality of service in the demonstration program through a variety of means. The Options for Long-term Care (Single Entry Point agencies) consumer satisfaction survey and the department's consumer complaint and appeals mechanisms (as described in Colorado State Rules vol. 8, "Medical Assistance", sections 8.057 through 8.059) will be extended to the demonstration program. The department will provide a complaint hotline for use by program participants. Nurses or.case managers under contract to the department will assess participants at least every six months to evaluate quality of care and to ensure that participants are receiving appropriate levels of service. The program administrator will be alerted if problems are discovered.

In addition to the plans described earlier in this section, the department will be directly engaged in quality assurance activities regarding the demonstration. Specifically, the program administrator will have the following quality assurance responsibilities:

a) Screen applicants for program eligibility in conjunction with the eligibility review committee.
b) Review participants' actual spendingas compared with their plans and allocations.
c) Monitor participants spending patterns for risk of financial exploitation.
d) Monitor participants' attendant support usage for risk of self neglect.
e) Provide oversight of contract Fiscal Intermediaries.
f) Review weekly consumer comments/complaints referred by Fiscal Intermediaries.

g) Review quarterly consumer satisfaction surveys. h) Periodically contact a sample of program consumers by telephone to determine their satisfaction and/or problems with the program.
i) Staff a program consumer complaint hotline.
j) Track payments and service utilization.

I. Financial Information and Budget Neutrality

1. Historical and Projected Costs

The department developed a profile to define a target population on which to base the data days, in accordance with the eligibility requirement in the governing legislation for the demonstration, that participants must have received Medicaid funded attendant suppcrt, for 12 months. The target population must have received a minimum of 230 home health aide visits during the year. This figure reflects historical profiling by the department, and is based on the assumption that project participants will be heavy users of home health services. This figure, 230 home health aide visits in a year, is equivalent to approximately 4.5 visits each week. The department determined that administrative costs, accrued both by the depaRment and by participants, wculd be difficult to justify for consumers whose utilization rate is less than 4.5 visits a week. The average utilization for individuals in the target population is over 675 home health aide visits a year, or approximately 13 visits a week.

Table 1 provides detailed information about services and expenditures for both the target population and for the overall Medicaid population for the past three years. This levet cf detail is available only for the past three years, because the department has made recent changes in its data management system, and such detailed information for older years was not retained. In all tables, "home health" includes skilled nursing, private duty nursing and home health aide visits. "Personal care" includes HCBS-EBD personal care, provided both by agencies and by relatives, HCBS-BI personal care and homemaker care. Table 2 provides summary information regarding home health and personal care expenditures for five previous years. This data was drawn from the HCFA 372 reports. Inflators were developed based on average annual growth rate in "per member per month" (pmpm) payments compounded annually given variable rates, as shown in table 3. These calculations resulted in a home health inflator of 32.48%, and a personal care inflator of 1.06%. Using 1997-98 as the base year, the last full year of data available, these inflators were applied to the home health pmpm of $2,380.13 and the personal care pmpm of $247.65 respectively in order to develop projections for the next six years, as presented in table 4. This table also shows projections for the target population both with and without the demonstration. Table 5 provides projections for overall expenditures for 150 clients, the maximum allowed under the governing legislation, both with and without the demonstration.

As the accompanying tables illustrate, the demonstration program is designed to be cost neutral for Medicaid expenditures. Individual allocations for services, distributed on a monthly basis, will be made based on each individual's history of service utilization. This allocation procedure will ensure that overall program costs will not exceed those that would have been made for the same clients, had they not been in the demonstration. During the demonstration, some individuals, through reassessments and utilization review, may have their allocations increased, while others, for similar reasons, may have reductions in their allocations. We expect these adjustments to require no more increases in program costs than would be experienced by the same group of clients being served through existing home health programs.

Historical and projected costs that appear in the accompanying tables are based on averages for the target population identified by the department. Since participation in the demonstration is strictly voluntary, we cannot predict which clients will apply for the program and what their needs will be. Therefore, based on a few known parameters, the department developed a profile to define a target population on which to base the data extract. Actual program costs provided in subsequent program reports will be calculated using costs for program participants, rather than for the target population.

Research costs to support the program evaluation are undetermined at this time. We intend to issue an RFP to obtain an evaiuation contractor. The evaluation cost may range from $15,000 to $25,000. We expect to request support from HCFA or private foundations in the future.

2. Cost Savings

The department anticipates the demonstration to show a cost savings, though it is impossible to project actual figures. Probable savings will result from provider overhead reductions, from changes in requirements for certification or licensure, and from participant savings.

According to WellMark Inc., the Federal Intermediary and Carrier, the average overhead cost per home health aide visit in fiscal year 1998 for all Colorado home health providers was $12.30 during that year. The Medicaid rate for home health aide visits in Colorado was $34.97, so that the average overhead cost was just over 35% of the rate. Under the demonstration, these overhead costs will not apply, as participants will not be using provider agencies, except possibly for emergencies. The project fiscal intermediary will charge fees for its services. These cannot be determined until contracts are awarded, but the fees are expected to be much less than $12.30 per visit, and much less than 35% of participants' allocations.

Conditions set forth in the Colorado Nurse Practice Act and the Nurse Aides Practice .Act require that certain tasks be performed by individuals with proper

licensure or certification. Many of the skilled nursing and Certified Nurse Aide visits reported in the accompanying tables occurred because of some of these conditions, such as nursing visits for training and supervision. For the purpose of this demonstration, attendants undertaking many of those restricted tasks will not be required to have certification or licensure. Participants therefore will have much greater flexibility in whom they hire and at what rate they pay, as long as they meet minimum wage requirements. Additionally, participants in the demonstration will not be required to have nursing visits for the purpose of training and supervising aides. We cannot predict how much savings will occur due to this lifting of restrictions, but it is reasonable to assume there will be savings.

Any unspent portion of a participant's allocation will be divided equally between the state, as cost savings, and the individual participant. As part of the attendant support management plan, approved by the program administrator, t.he participant will identify the designated purpose for use of these savings. The participant may use this savings incentive to cover costs for other services and equipment that promote the participant's independence. Any savings accrued by the participant will be administered and disbursed by the project fiscal intermediary under the participant's direction. The amount of savings will vary among participants, and the rate of savings will change for any given participant as needs change. It is not possible to project what program savings might be gained through this mechanism, though with such incentives for participants, some savings no doubt will occur.

J. Implementation / Timeframes

The implementation plan for the demonstration program includes a pre-implementation phase.

During this phase, program staff will complete and issue the RFP for Fiscal Intermediaries, and the department will award contracts to the successful bidder(s). The department will develop final program rules, which must be passed by the Medical Services Board prior to implementation. Program staff, with support from several community agencies, will train case managers and complete development on curriculum and materials for the attendant support management training for program participants.

The program implementation phase will involve participant training, program enrollment, service provision, program monitoring and reassessment and program evaluation. The program work plan further details program implementation and timelines.

K. Evaluation

The Department and the Advisory Committee are planning an evaluation to be incorporated into the operation of the project as required by the enabling legislation. The evaluation plan is still being developed. It will contain several process measures and focus on as many outcome measures as possible. A quasi-experimental design comparing project clients to non-project clients during the same time periods will be used. We will attempt to standardize for case mix. For some factors, historical data may be obtained on project clients. We will gather and analyze data on hours of care, frequency of attendants failing to show, flexibility in client schedules, clients meeting their goals, hospitalization rates, emergency room visits, service costs, infections, number of appeals related to attendant support, client satisfaction, attending physician satisfaction, increases in training or school attendance and employment. We are considering making an application to HCFA for evaluation funding.

Requested Medicaid Waivers and Costs Not Otherwise Matchable

1. Waivers

The following waivers are requested for the demonstration program:

Section 1902(a)(10)(B) regarding Comparability, to permit the provision of services under the demonstration that will not otherwise be available under the State Plan. Benefits (i.e., amount, duration and scope) may vary by individual based on assessed need.

Section 1902(a)(1) regarding Statewideness, to permit the State to operate the demonstration within an area which does not include all political subdivisions of the State.

Section 1902(a)(10)(C)(i) regarding Income and payments received under the demonstration pro£ established under State and Federal law for Medi permitted to accumulate cash in a separate account. Regarding income limitations, to permit the state to demonstration to individuals whose income does not exclusion of source limits will also be able under the Federal benefit rate (FOR) in accordance with 42 CFR 435.211, and who receive services under a Home and Community Based Services waiver.

Section 1902(a)(27) regarding Provider Agreements, to permit the provision of care by individuals who have not executed a Provider Agreement with the State Medicaid agency.

Section 1902(a)(32) regarding direct payments to providers, to permit payments to be made directly to Fiscal Intermediaries acting under the direction of beneficiaries.

Section 1902(a)(37)(B) regarding Payment Review, as prepayment review may not be available for disbursements by individual beneficiaries to their caregivers/providers.

2. Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act, the State requests that the following expenditures made by the State for the costs identified below (which may not otherwise be included as State expenditures matchable under section 1903) be regarded, for the duration of the project, as expenditures under the State's title XIX plan:

a) Expenditures to employ members of a recipient's family as caregivers.

b) Expenditures to provide non-traditional services presently not included as optional State Plan Services under Title XIX; i.e., to provide for Fiscal Intermediary services as a part of the demonstration project.

c) Expenditures regarding payment for the provision of services to recipients. Specifically, payment will be provided to Fiscal Intermediaries acting under the direction of recipients prior to the delivery of service.